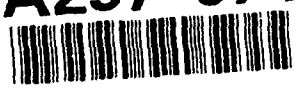

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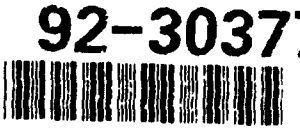
A RAND NOTE

The Limits of the Czar's Ukase: *Drug Policy at the Local Level*

John G. Haaga, Peter Reuter

June 1990



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The Limits of the Czar's Ukase: Drug Policy at the Local Level

John G. Haaga and Peter Reuter†

As the concern with drugs has risen ever higher, enormous political attention has been focused on the need for a national strategy. Congress created a new drug czar's office to coordinate federal antidrug efforts. It also charged this new office with setting, for the first time, a national drug control strategy. A focus on national strategy, however, is misplaced because it ignores the local nature of drug problems.

During the second half of the 1980s, Congress expressed growing frustration with the internecine feuds between federal agencies and the failure of various coordinating mechanisms to prevent strategic and tactical conflict. In 1984, the executive branch responded by proposing legislation creating the National Drug Enforcement Policy Board,[1] chaired by the Attorney General. Officials from other federal drug enforcement agencies, such as the Customs Service and the Drug Enforcement Administration, were seconded as staff for this new interagency organization; it had only a small staff of its own. In 1987, the President expanded the Board to include the "demand side" agencies, such as the National Institute on Drug Abuse and the Department of Education, and rechristened it the National Drug Policy Board.[2] Again, the Board was staffed by personnel from the member agencies.

The failure of the Board, even in its expanded form, to set strategy was clear. Its products, such as the National and International Drug Law Enforcement Strategy, were simply compendia of descriptions of existing programs which did not attempt to relate means to ends or to set budget priorities.[3] Struggles about which agency was

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1. Comprehensive Crime Control Act of 1984, Pub. L. No. 98-473, § 1303, 98 Stat. 2168 (codified at 21 U.S.C. § 1202 (Supp. 1988)).

2. Exec. Order No. 12,590, 3 C.F.R. 218 (1988).

3. *See generally* GEN. ACC'T OFF., PUB. NO. GAO/GGD-88-24, NATIONAL DRUG POLICY BOARD: LEADERSHIP EVOLVING, GREATER ROLE IN DEVELOPING BUDGETS POSSIBLE (1988).

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the "lead agency" with respect to interdiction were carried out openly. The Board seemed little more than a medium for conducting turf battles. Certainly it made no effort to provide direction for state and local governments.

In 1988, faced with a rapidly deteriorating situation marked by the increased availability of drugs and the greater incidence of drug-related crime and injury, Congress forced the administration to accept the creation of a new independent office to set national drug policy.[4] Though Congress's primary concern was the lack of coordination among federal agencies, it also required the Office of National Drug Control Policy to provide annual reports setting out a *national* strategy for dealing with the drug problem,[5] along with a set of goals to be achieved within two years and ten years.[6] The first strategy, published in September 1989, has been the centerpiece of discussion of drug policy from the time that its first draft became widely circulated.[7]

We argue that, whatever the need for some central policy office for the federal drug control effort, drug policy is essentially a state and local affair. The federal government may lead, cajole, and finance, but the nation's drug policy emerges primarily out of the decisions of officials at other levels. The federal government's influence on these decisions is certainly significant, but states and cities will continue to exercise considerable autonomy. Moreover, such autonomy is entirely appropriate; the rationale for large-scale federal intervention in drug policy is weak. Substantial variation in the drug problems of different areas makes local variation in policy appropriate. It is at the local level that there is most need for coordination among the different agencies involved in drug policy. Finally, the great uncertainty about the effectiveness of various instruments of drug policy makes local experimentation worthwhile.

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4. Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690 § 1002, 102 Stat. 4181, 4181 (codified at 21 U.S.C. § 1501 (Supp. 1989)).

5. Note that the title of the office has the word "national" rather than "federal." We have a National Security Council because the federal government does indeed have dominant responsibility for defense of the nation. On the other hand, the Federal Trade Commission's name recognizes that anti-trust is a shared responsibility. We take the use of "national" here to represent Congress's rather imperial view of the director's, or "drug czar's," office.

6. Anti-Drug Abuse Act of 1988, at § 1005, 102 Stat. at 4185 (codified at 21 U.S.C. § 1504(Supp. 1989)).

7. Off. of Nat'l Drug Control Policy, The White House, National Drug Control Strategy (1989) [hereinafter Strategy].

I. Local Variation

The most commonly used surveys of drug use only measure national levels. The National Household Survey[8] and the High School Senior Survey[9] are national monitoring systems, with few local counterparts.[10] Discussion tends to focus on the worsening or improvement in various aspects of the *nation's* drug problem. This focus masks considerable variation at the local level.

The variation takes at least two forms. First, communities differ considerably in the extent of illicit drug use and in the pattern of specific drugs consumed. Though it is impossible to get precise estimates of illegal drug use from existing data sources, the information available suggests that there are large and persistent local differences in the overall prevalence of illicit drug use. Second, the extent and nature of the problems arising out of drug use vary. Washington, D.C., whose problems captured national headlines during 1988 and 1989, has witnessed what reasonably might be called an epidemic of violence surrounding the distribution of drugs.[11] The data for many other major cities, such as San Francisco and Chicago, point to no such outbreak of violence. Intravenous drug use has been identified as a major factor in the spread of the HIV infection in the New York area but a relatively minor one in many other cities.[12] Local variation in the consequences of drug use has implications for appropriate policy measures.

A. Variation in Drug Use Patterns

Two major data collection systems measure drug use patterns in metropolitan areas. The longer series comes from the Drug Abuse

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8. The National Household Survey on Drug Abuse, sponsored by the National Institute on Drug Abuse (NIDA), has been conducted every two or three years since 1972. The results of the 1988 survey, available in the form of summary statistics, can be found in NIDA, Highlights of the 1988 National Household Survey on Drug Abuse (Aug. 1989) (press release on file with *Yale Law & Policy Review*).

9. NIDA sponsors an annual survey of high school seniors, conducted by the University of Michigan's Institute for Social Research. The results are published annually as part of a program titled, "Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth."

10. Some school districts carry out occasional surveys of high school drug use. *See, e.g.*, P. Reuter, J. Haaga, P. Murphy & A. Praskac, Drug Use and Drug Programs in the Washington Metropolitan Area 76-91 (The RAND Corporation Report No. R-3655-GWRC, July 1988) [hereinafter P. Reuter]. Questionnaires, sample designs, and methods of analysis vary greatly, and it is usually impossible to use these surveys either to monitor trends over time or to make comparisons among regions.

11. *See infra* text accompanying notes 26-28.

12. *See infra* text accompanying notes 35-37.

Warning Network (DAWN).[13] Since 1972, the federal government has collected data on illicit drugs from hospital emergency rooms (ERs) and medical examiners (MEs) as part of the DAWN system.[14] More recently, the National Institute of Justice established the Drug Use Forecasting (DUF) system.[15] DUF collects and analyzes urine specimens quarterly from a sample of arrestees in selected cities. The sample is weighted toward persons arrested for felonies and weighted against persons arrested for drug offenses.[16] Urinalysis of arrestees is a leading predictor of change in a number of consequences of drug use, such as community crime, drug-related emergency room episodes, and child abuse.[17]

Table 1 shows ME mentions of four important drugs (cocaine, heroin, amphetamines, and PCP) per 100,000 residents in eight metropolitan areas. The ranges for two of the drugs are quite striking. For PCP, Washington dwarfed all others, with a rate more than double that of the next highest city, Los Angeles.[18] For amphetamines, San Diego has an even more striking eminence.

There are also considerable ranges for heroin and cocaine. Chicago shows much more modest levels of heroin use than do the

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13. The DAWN data are published annually as NAT'L INST. ON DRUG ABUSE, DAWN ANNUAL DATA (Statistical Series I).

14. A sample of ERs in 21 metropolitan areas provide data on the number of admissions involving mentions of a wide variety of illicit drugs. Medical examiners in 27 areas provide data on the number of deaths in which these drugs appear to have played a role. In the DAWN system, the unit of measurement is a specific drug "mention," recorded when a substance is reported by the patient or an accompanying individual, or detected by the attending medical professional (in ERs) or by the Medical Examiner. Many cases involve more than one drug mention; in 1988, the average number of mentions per case by ER was 1.63 and by ME was 2.43, showing the prevalence of the simultaneous use of different drugs. NAT'L INST. ON DRUG ABUSE, DAWN ANNUAL DATA at 4-5 (Statistical Series I, 1988). For comparison among cities, the ME data are more suitable than the ER data. Interpretation of the ER data for community comparisons requires considerable care. The DAWN ER sample is not a random sample representing each metropolitan area with equal probability. Cities may differ in the types of catchment area that happen to be represented in their DAWN sample. Thus, even ER admissions per capita do not provide an indicator of a city or metropolitan area's drug problems that can be compared to other cities. For a given city, changes in DAWN ER mentions over time within a consistent sample of ERs may provide a reliable indicator of trends, even if absolute levels of drug use cannot be compared reliably across cities for any one year. *See id.* at 6-7 (on limitations of DAWN data).

15. DUF collects data from arrestees only in the central booking facility of each city. It does not include arrests made by suburban police forces in any jurisdiction. NAT'L INST. OF JUST., U.S. DEPT. OF JUST., DRUG USE FORECASTING, Sept. 1989, at 2.

16. *Id.*

17. A recent analysis of four years of urinalysis data in D.C. suggests that trends in arrestee drug use can predict changes in these effects by as much as one year in advance. *Id.* at 8.

18. *See also* Thombs, *A Review of PCP Trends and Perceptions, 1989*, 104 PUB. HEALTH REP. 325 (1989).

Table 1: Drug-related Deaths per 100,000 Residents in Selected Metropolitan Areas, by Drug, 1988, Reported by Medical Examiners+

Metropolitan Area	Population* (millions)	Cocaine	Heroin	Amphetamines	PCP
Chicago	6.6	1.3	0.9	0.0	0.1
Detroit	4.0	2.3	2.3	0.0	0.0
Los Angeles	7.5	6.0	5.6	0.4	0.9
New York	10.5	11.2	7.0	0.0	0.3
Philadelphia	4.0	6.6	5.2	0.6	0.2
San Diego	1.9	4.1	4.8	4.8	0.2
San Francisco	3.3	4.9	5.2	1.9	0.3
Wash., D.C.	2.0	5.3	7.4	0.0	2.0

+More than one drug may be mentioned per death; therefore, the total number of deaths may be less than the sum across any one row.

SOURCE: NAT'L INST. ON DRUG ABUSE, DAWN ANNUAL DATA at 5, ch. 4, and table 5.02 (Statistical Series I, 1988).

* Population covered by reporting Medical Examiners.

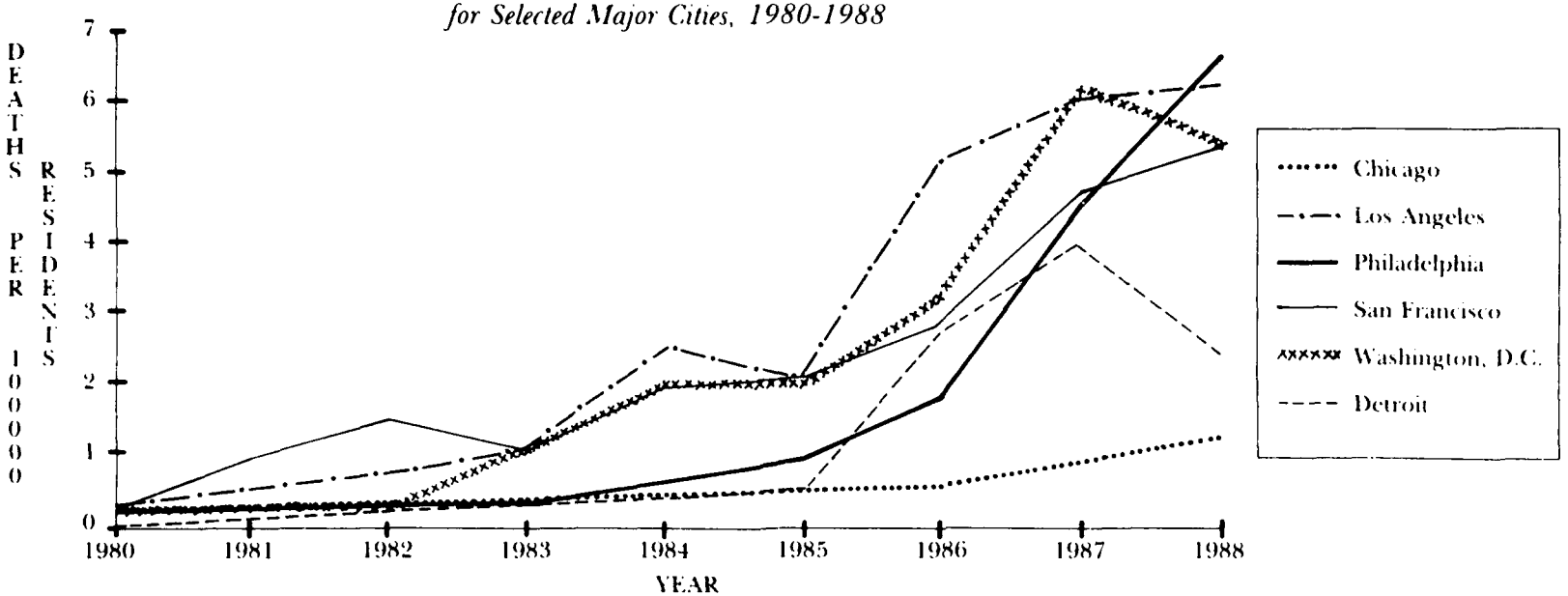
other cities. In a recent study of arrestees in Miami, heroin was dropped from the data base on urinalysis because there were so few cases involving that drug; only cocaine and marijuana were detected in a non-trivial fraction of the population.[19]

Cocaine showed less variation across cities in the DAWN and DUF data than did the less popular drugs. As Figure 1 shows, the number of cocaine-related deaths per 100,000 residents grew during the 1980s in nearly all metropolitan areas. Even so, the timing of the spread of cocaine varied across cities. For example, in many cities, cocaine became the dominant drug in the DAWN system by 1986, while for the District of Columbia, cocaine did not supplant PCP in the ER data until the first half of 1988 and still has not supplanted heroin in the ME data.[20] Cocaine use in Chicago has not increased to nearly the same extent as other large cities. In 1988, for the first time in recent years, the ME data showed decreases in cocaine-related death rates in some cities (Detroit, Washington), while other cities (notably Philadelphia) continued to show increases (Figure 1).

19. J. Goldkamp & M. Gottfredson, Drug Abuse and Misconduct During Pre-trial Release Among Felony Defendants (unpublished paper) (sponsored by NIJ).

20. NAT'L INST. ON DRUG ABUSE, DAWN SEMIANNUAL REPORT, TREND DATA (Statistical Series G, No. 23, 1989).

Fig 1: Cocaine-Related Deaths Reported by Medical Examiners for Selected Major Cities, 1980-1988



SOURCES: NAT'L INST. ON DRUG ABUSE, TRENDS IN DRUG ABUSE RELATED HOSPITAL EMERGENCY ROOM EPISODES AND MEDICAL EXAMINER CASES FOR SELECTED DRUGS 1976-1985, at 38 (Statistical Series H, No. 3, 1987) (reporting data from consistent samples from 1976-1985); NAT'L INST. ON DRUG ABUSE, DAWN SEMIANNUAL REPORT, TREND DATA (Statistical Series G, No. 19, 1987) (reporting data for 1984-1986); NAT'L INST. ON DRUG ABUSE, DAWN SEMIANNUAL REPORT, TREND DATA (Statistical Series G, No. 23, 1989) (reporting data for 1986-1988); NAT'L INST. ON DRUG ABUSE, DAWN ANNUAL DATA at ch. 4 (Statistical Series I, 1988).[21]

[21]Data from distinct consistently reporting panels were compared during periods of overlap and those from the earlier series were multiplied by the proportional difference between the two in order to simulate a single consistent panel for 1980-1988.

Table 2 shows the percentage of male arrestees testing positive for any illegal drug (except marijuana) in thirteen cities participating

Table 2: Percentage of Male Arrestees Testing Positive for Selected Illegal Drugs, Oct.-Dec. 1988

City	Any Drug (Excluding Marijuana)	Cocaine	Opiates	Amphetamines	PCP
Chicago	69	63	22	*	13
Dallas	49	43	3	8	*
Detroit	58	54	10	0	*
Kansas City	44	41	2	2	2
Los Angeles+	65	55	15	5	6
New Orleans	70	64	5	*	5
New York	76	67	25	0	2
Philadelphia	79	75	12	1	1
Phoenix	40	34	7	12	*
Portland	47	37	11	9	0
St. Louis	47	38	6	0	9
San Diego	76	51	27	32	4
Washington, D.C.	68	62	11	*	29

*Denotes less than 1%.
+Data for Los Angeles collected July-Sept. 1988.

SOURCE: NAT'L INST. OF JUST., U.S. DEP'T OF JUST., DRUG USE FORECASTING, June 1989, at 4-5; NAT'L INST. OF JUST., U.S. DEP'T OF JUST., DRUG USE FORECASTING, Apr. 1989 (Los Angeles data).

in the DUF program in 1988.[22] Fewer than half of the male arrestees tested positive for drugs in several cities, while in others (New York, Philadelphia, San Diego) more than three-quarters of arrestees tested positive.

The distinctive regional patterns of use of rarer drugs found in the DAWN data are also reflected in the DUF data: PCP is common in Washington, D.C., and uncommon elsewhere, amphetamines are more common in western cities, and use of opiates varies widely across cities. There is much less variation for cocaine than for other drugs; no city showed fewer than 34% positive (Phoenix), and the

22. Arrestees are a select group, of course, but there are no comparable indicators of drug use in the general population. Differences in the "catchment areas" of central intake facilities could also vitiate comparisons of DUF data across cities.

highest figure was 75% (Philadelphia). Cocaine has become a national drug in a way that even heroin has not.[23]

Why have drugs shown such varied epidemiological patterns? Aside from marijuana, no drug other than cocaine has been the agent of a truly national epidemic. Even heroin has been confined primarily to a relatively small number of cities in the Northeast, northern Midwest, and West.[24] The rest of the nation has remained almost uninfected. Most other drugs, such as amphetamines and PCP, have been localized in a very small number of metropolitan areas. Sometimes they have occasioned short epidemics in other areas, but they have essentially disappeared after a few years.[25]

We offer no explanation for these varying patterns of use. What is important for all policymakers are the significant differences in drug consumption patterns across metropolitan areas.

B. Variation in Drug-Related Problems

The drug problem that faces each community is not simply a function of the level of drug use, no matter what the drug. It is also a problem of public order and of the transmission of AIDS. In some cities, drug markets have engendered enormous increases in the level of violence; in others, it can be inferred that the recent growth of drug markets has had little effect on the extent of violence. Similarly, in some cities, drug use has been the major source of the spread of the HIV infection, while in others drug use has been involved only moderately.

1. Drug-related violence. Direct measures of drug-related violence are not available, either nationally or for individual cities. At best, there are occasional police estimates of the share of homicides that are related to drug use and/or distribution. Nonetheless, inspecting trends in homicide rates (per 100,000 population) in a few large cities over the last decade (Figure 2) can be instructive.

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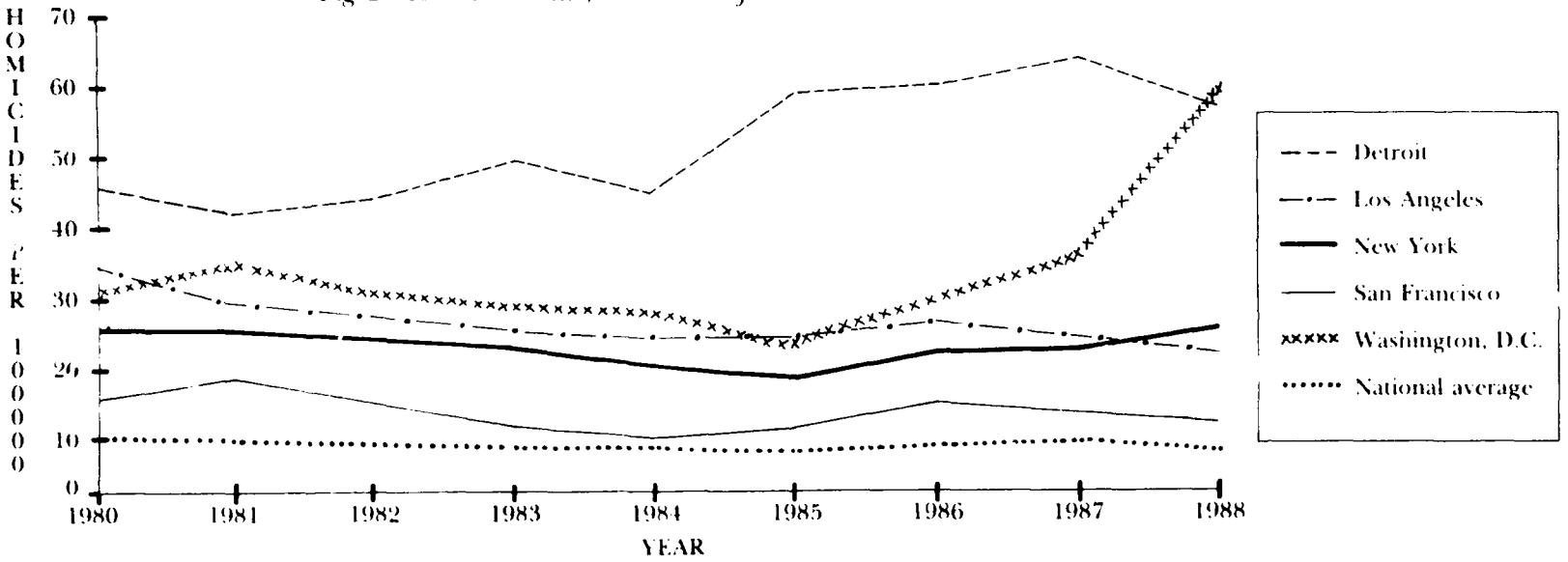
23. The DAWN and DUF data show some inconsistencies for individual cities, particularly for heroin. For example, Chicago has the lowest heroin rate in the ME sample but the third highest rate for opiates in DUF. Similarly, San Diego has the third lowest rate in the DAWN sample but the highest rate in the DUF data. These discrepancies may reflect the fact that DUF samples only the inner city while DAWN covers the metropolitan area.

24. *See generally* NAT'L INST. ON DRUG ABUSE, EPIDEMIOLOGY OF HEROIN: 1964-1984 (1985) (data on national and regional patterns of heroin use).

25. For example, several cities, including San Antonio, Miami, and Kansas City, experienced brief but sharp rises in PCP-related deaths around 1978. Several years later, the number of PCP deaths was negligible. *See* NAT'L INST. ON DRUG ABUSE, TRENDS IN DRUG ABUSE RELATED HOSPITAL EMERGENCY ROOM EPISODES AND MEDICAL EXAMINER CASES FOR SELECTED DRUGS 1976-1985, at 128 (Statistical Series H, No. 3, 1987).

Fig 2: Homicide Rates, Selected Major Cities, 1980-1988



Source: FBI, Uniform Crime Reports for the United States (published annually, statistics in Figure 2 reprinted in Statistical Abstract of the United States (published annually)).

The District of Columbia is a good example. In 1988, its homicide rate rose by two-thirds from a level that was already a record high for Washington; the 1989 rate is 20% higher than the 1988 rate.[26] The Metropolitan Police Department reports that, where a motive for the homicide could be determined, drugs accounted for about 80% of killings in the first half of 1988 (the last period for which such an estimate has been published). This estimate stands in marked contrast to an estimated 21% in 1985.[27] The killing epidemic may be a consequence of the expansion of street drug markets.[28]

In other cities, there has been no such killing epidemic. Overall, the national homicide rate for 1988 was 15% below the 1980 level, though 6% above the 1985 figure. Looking just at three of the "entry" cities for drugs (Los Angeles, New York, and San Francisco), we observe declines for two of the cities (Los Angeles and San Francisco) and a moderate rise for New York (see Figure 2). Comparing 1988 with the starting point for the crack epidemic, 1985,[29] the record is still very mixed, and there is no consistent pattern. An unweighted average for the twelve largest cities was up 20%, while four of the cities showed an actual decline.[30] The divergent trends in homicide rates among cities (Figure 2) contrast with the broadly similar trends in ME data reflecting cocaine use in the same cities (shown above in Figure 1).

2. Intravenous drug abuse and AIDS. The second greatest source of the spread of the HIV infection in the United States is

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26. Telephone interview with Reggie Smith, Metropolitan Police Department, Washington, D.C. (Jan. 29, 1990). There were 227 homicides in 1987, 373 in 1988, and 438 in 1989.

27. Off. of Crim. Just. Plans & Analysis, Homicide in the District of Columbia 23 (1988). Data on homicide victims show that 45% had traces of cocaine present in their systems in 1988, compared to 17% of 1985 victims; for PCP, the 1988 figure was 22% and the 1985 figure 15%. *Id.* at 10. Of the roughly half of assailants for whom drug urinalysis results were available, there was little change in the prevalence of drugs over the same time period. *Id.* at 14.

28. Causes include disputes over drug transactions (e.g. disagreement about the quantity of drugs or the price) and territories, and killings by a user seeking money for purchase of drugs. *Id.* at 23-25.

29. Strategy, *supra* note 7, at 3.

30. This does not purport to be a complete analysis of homicide trends. *See generally* Land, McCall & Cohen, *Structural Covariates of Homicide Rates: Are There Any Invariances across Time and Social Space?* 95 Am. J. Soc. 922 (1990) (discussion of empirical research on variation in homicide rates). Homicide is a relatively rare event and the time series for smaller cities are unstable. Demographic trends, such as changes in the age and sex composition of a city's population, can make a major difference in the "expected" homicide rate. Yet, if crack had led to a significant increase in violence in the large cities of the nation, we might reasonably expect to see perceptible changes in the homicide rates.

needle sharing by intravenous drug abusers (IVDAs).[31] In addition, intravenous (IV) drug use is the primary source of AIDS transmission to heterosexuals whose sexual partners are IV drug users and to children whose mothers are infected before or during pregnancy.[32] As of September 1989, 21% of all reported AIDS cases were IVDAs, a sharp increase from the 16.6% in October 1987 (in 1989, another 7% of cases were classified as IVDAs and homosexual).[33]

HIV prevalence among IVDAs across regions of the country varies strikingly. For individuals reporting IV drug use, the highest rates of HIV infection occur in and around New York City, where between 50% and 60% of IV drug users test positive. This figure contrasts dramatically with other cities; San Francisco, for example had half the prevalence rates among IVDAs, and Los Angeles had less than one-tenth.[34] By October 1987, New York State had recorded only 20% more AIDS cases than California, but 32.7% of the AIDS cases in New York were attributed to IV drug use, compared to only 2.5% in California.[35] By the same year, just 3% of Texas's AIDS cases were IV drug users, compared to 47.7% of New Jersey's.[36]

The explanations for these differences cannot be readily determined. In part, they may be due to differences in local practices that affect the likelihood of individual IVDAs using a needle already used by large numbers of other IVDAs. New York, especially, has a long tradition of commercial needle sharing among strangers ("shooting galleries") which likely increases the risk of infection through this route. Sharing among acquaintance circles may be less conducive to the spread of the HIV infection.[37]

C. The Implications of Local Variation in Drug Problems

"Drug policy" is a generic term for diverse laws, emphases within programs, and allocations of public budgets across programs. Differences in the pattern and prevalence of drug use, the level of violence associated with drug distribution, and the extent of HIV

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31 Nat'l Res. Council, AIDS, Sexual Behavior and Intravenous Drug Use 187 (1989)

32 *Id.*

33 *Id.* at 236; Centers for Disease Control, HIV/AIDS Surveillance, Oct. 1989, at 8.

34 Nat'l Res. Council, *supra* note 31, at 235.

35 *Id.* at 236.

36 *Id.*

37 M. Kleiman & R. Mockler, AIDS and Heroin Strategies for Control 14-15, 21 (The Urban Institute, Project Report, 1988); DesJarlais & Hunt, *HIDS and Intravenous Drug Use*, in Nat'l Inst. of Just., U.S. Dept. of Just., AIDS Bulletin, Nov. 1987, at 3-4.

infection in the drug-using population should influence the components of these policies. For some communities, tough user sanctions, strongly enforced, may be justified. Where users are buying in street markets, generating violence and disorder, a crackdown focused on street market buyers may be effective, while in other communities the same policy would be an inefficient use of criminal justice resources. Similarly, needle distribution programs may be appropriate in communities where there is a high level of HIV infection among intravenous drug users but little danger of increased recruitment of drug users as a result. For other communities, with lower rates of intravenous drug abuse and related HIV infection, there may be little gain from needle distribution and substantial risk of increasing the extent of intravenous drug abuse.

Two examples illustrate these points: (1) the impact of local variation on the role of street enforcement, and (2) the impact of variation in heroin abuse and HIV infection on treatment policies.

1. Street enforcement. The problems of persistent and threatening street markets put great pressure on city police departments to focus their attention on eliminating these markets.[38] This pressure is felt by all jurisdictions, including some that have experienced few problems. For example, a suburban prosecutor in the Washington metropolitan area noted that the drug squad in his county had increased tenfold in the last four years and now was generating a large number of minor possession cases that his office was unwilling to prosecute.[39] Moreover, he saw no great threat in his affluent jurisdiction from the operation of street markets.[40] For him, the pressure for such street level enforcement constituted a major and inappropriate reallocation of resources away from pursuing more serious property crime, which the police no longer so actively pursued. Yet the drumbeat of concern about drug-related violence is such that it is a major battle for him to avoid a large scale commitment to low level drug enforcement.[41]

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38. For a review of the potential and limitations of street market enforcement, see Kleiman & Smith, *State and Local Drug Enforcement: In Search of a Strategy*, in DRUGS AND CRIME (M. Tonry & J. Wilson eds.) (forthcoming). *See also* NAT'L INST. OF JUST., U.S. DEP'T OF JUST., STREET-LEVEL DRUG ENFORCEMENT: EXAMINING THE ISSUES (M. Chaiken ed. 1988).

39. Communication to the authors.

40. Indeed, these markets were less "street" than "parking lot," in which the transactions were executed between buyers and sellers in cars. The disorder surrounding these markets appeared to be quite modest.

41. Communication to the authors.

For the District of Columbia, on the other hand, the need to suppress the street markets and associated violence is acute. Aggressive enforcement activities against users who patronize these markets could be justified. By making it risky for users to enter these markets, it might be possible to break up at least some of them. The consequences for drug use might be quite modest and, by themselves, not worth the costs. The dispersion of the trade to more discreet settings, however, could yield major gains in terms of safety and community quality of life.

2. Treatment Programs. The size and characteristics of the drug-using population can affect the nature of the tasks faced by the public treatment system. For example, the number of heroin users in a city should affect the design of the system, depending on the particular treatment approach adopted.

Heroin dependence is, as yet, the only form of drug dependence for which there is a proven pharmacological maintenance therapy, namely oral administration of methadone.[42] In cities where heroin epidemics of the 1970s left behind cohorts of long-term addicts, now mostly in their mid-30s, public treatment systems have traditionally emphasized provision of methadone, under medical supervision, with varying combinations of support services and varying degrees of commitment to progressive reduction of dosages. There has been fierce controversy over the goals of methadone treatment and disappointment in its general failure to "cure" addiction (in the sense of inducing abstinence by large numbers of those treated).[43] At least until the AIDS epidemic ravaged intravenous drug abusers, many cities and states had begun to move away from methadone maintenance as a preferred therapy for heroin addicts.[44] Those in charge of public treatment systems in cities with severe problems of heroin addiction can choose either to emphasize methadone maintenance or to rely on therapeutic communities and outpatient programs for heroin users, with the structure, staffing, and financing of programs varying accordingly. The choice would depend on local experience with programs of either type, on considerations of cost, and on beliefs concerning the basic goals for treatment. There are many arguments for and against methadone maintenance in theory and in practice. The relevant point is that because no city has solved

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42. *See generally* Dole, *Implications of Methadone Maintenance for Theories of Narcotic Addiction*, 260 J.A.M.A. 3025 (1988).

43. Kirn, *Methadone Maintenance Treatment Remains Controversial Even After 23 Years of Experience*, 260 J.A.M.A. 2970 (1988).

44. Cooper, *Methadone Treatment and Acquired Immunodeficiency Syndrome*, 262 J.A.M.A. 1664 (1989).

its heroin problem, reasonable people disagree on basic issues of how to address it and there is a strong case for local autonomy in setting treatment policy for heroin addicts.

Treatment programs for those dependent on non-opiate drugs are diverse, and there is a great deal of uncertainty about the effectiveness and appropriateness of different types of treatment for different users. The current rule of thumb cited by treatment professionals is that "you treat the patient, not the drug." With the exception of heroin, the choice of treatment depends on characteristics of the dependent person (personality, motivation, degree of social and family support, insurance coverage) rather than the particular drug to which she happens to be addicted. Thus, the variations among cities in the popularity of particular drugs may not significantly affect the optimal design of the treatment system.[45] But variation in the numbers, ages, sex, and personal and family characteristics of clients entering the public treatment system would determine the relative importance of residential, daycare, and outpatient facilities, group homes and aftercare programs, adolescent and adult-oriented programs, and other programs.

Where HIV infection has spread to a significant percentage of the IVDA population in a community, drug policy must reflect that fact. For such cities, a focus on eliminating shooting galleries and getting intravenous drug users into some form of treatment are the dominant priorities. The risks and benefits associated with needle exchange programs change. Consideration may have to be given to removing or relaxing prohibitions on the unlicensed possession of hypodermic needles.[46]

The preceding examples show just some of the ways in which the variation among localities in the nature and severity of drug use and drug trafficking and violence affect the costs, benefits, and feasibility of different policies. Differing local conditions demand diverse responses.

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45. This conclusion would have to be modified if new forms of pharmacologic treatment of dependence on some drugs prove successful. Different drugs present different problems of diagnosis and requirements for detoxification; for example, a city with a significant PCP problem needs trained staff in emergency medical services for handling the psychotic and violent reactions occasionally exhibited by users of this drug. *See* Price & Giannini, *Management of PCP Intoxication*, AM. FAM. PHYSICIAN, Dec. 1985, at 115.

46. Police targeting of individuals carrying such equipment has the effect of increasing the attractiveness of shooting galleries. *See* Kleiman, *AIDS, Vice and Public Policy*, 51 LAW & CONTEMP. PROBS. 360, 363 (1988).

II. Instruments of Drug Policy

State and local agencies do not serve only as conveyor belts, carrying national drug policy to the citizens. By their nature and historically, local agencies have wide discretion; drug policy as it affects local drug problems is the sum of decisions taken mostly at local levels. Though the renewed salience of drug abuse as a national political issue has increased centralization, attempts to impose a national drug strategy from above are both inappropriate and unworkable. The real coordination needs to be at the local level.

A. The Local Nature of Implementation

A conventional taxonomy of drug abuse policy uses Enforcement, Treatment, and Prevention as major headings.[47] Enforcement can be further subdivided into source-country programs, interdiction, high-level enforcement, and street-level or retail enforcement. Each class of policies has been the responsibility of a different set of institutions. Agencies of the federal government are solely responsible for implementation of source-country programs and interdiction. High-level enforcement is a mixed federal/local responsibility; especially in recent years, task forces from different agencies at different levels of government have cooperated in investigations targeted at large importing or wholesaling organizations. In contrast, most arrests and sentences are carried out by local agencies, and local and state courts and prisons mete out most of the punishment for drug offenses. In 1986, the most recent year for which post-arrest data are available, approximately seven times as many persons were sentenced to incarceration in state prisons and local jails for felony drug offenses as were sentenced to federal prisons.[48]

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47. *See, e.g.*, J. POLICH, P. ELLICKSON, P. REUTER & J. KAHAN, STRATEGIES FOR CONTROLLING ADOLESCENT DRUG USE (The RAND Corporation Report No. R-3076-CHF, Feb. 1984) [hereinafter J. POLICH].

48. There were 8,152 federal prison sentences for drug law violations from July 1, 1985 to June 30, 1986. BUREAU OF JUSTICE STATISTICS SPECIAL REPORT, FEDERAL OFFENSES AND OFFENDERS: SENTENCING AND TIME SERVED, June 1987, at 2. In 1986, in contrast, there were approximately 60,000 sentences to prisons and jails resulting from felony indictments in state courts. There were 48,651 sentences of incarceration for drug trafficking, BUREAU OF JUSTICE STATISTICS BULLETIN, FELONY SENTENCES IN STATE COURTS, 1986, Feb. 1989, at 3, and an estimated 11,743 for drug convictions. This estimate is reached as follows: the data show 202,463 convictions for "other felonies," *id.* at 2, an estimated 10% of which were for drug possession. *Id.* at 3. Of the "other felonies" convictions, 58% resulted in incarceration. *Id.* at 2. Assuming that those convicted for drug possession were sentenced to incarceration at the same rate as all felons in the "others" statistical category, the extrapolation yields the 11,743 figure. The estimate is rough, but supports the point that there is an enormous disparity between the

Implementation of treatment and prevention programs is almost entirely the responsibility of local agencies or school districts. The federal government's main role is to fund some of these activities, attaching various conditions to its grants. The federal government also influences the direction of policy through its dominant role in sponsoring research and technical assistance and through a more diffuse form of moral suasion, exercised now by the Office of National Drug Control Policy in the executive branch.

1. Enforcement. The frontline enforcement agency is the city or county police department. The intensification of drug law enforcement in recent years has been the work of local police agencies, prosecutors, courts, and corrections agencies. While 85% of those in prison for a drug-related offense in 1988 were held in state prisons, only 15% were in the federal system.[49] More specifically, enforcement has been the work of large-city police departments. Figure 3 shows the arrest rates (per 100,000 population) for drug abuse offenses from 1980 to 1987. Central cities with populations greater than 250,000 account for most of the increase in the national rate; the rate for central cities rose from 402 per 100,000 in 1980 to 944 per 100,000 in 1988. These central cities contained 19% of the population nationwide that was covered by the Uniform Crime Reports (UCR) to the Federal Bureau of Investigation. In suburban areas, containing 40% of the population covered by the UCR, arrest rates for drug offenses rose much more slowly, from 213 to 305 per 100,000 residents, during the same period.[50]

Local agencies have wide latitude, not only in tactics of drug law enforcement, but also in strategies. Police determine the timing and locations of the "sweeps" that have become common.[51] Between them, police and prosecutors determine enforcement priorities. Even without legislation or formal announcements, many jurisdictions effectively decriminalized marijuana possession during the 1970s by not making it a priority for the law enforcement system.[52] In big cities hard pressed by cocaine sales and attendant violence, the enforcement of the marijuana prohibition does not occupy much

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state and federal systems in the absolute number of drug-related incarcerations. Additional commitments to local jails resulted from misdemeanor convictions in state courts.

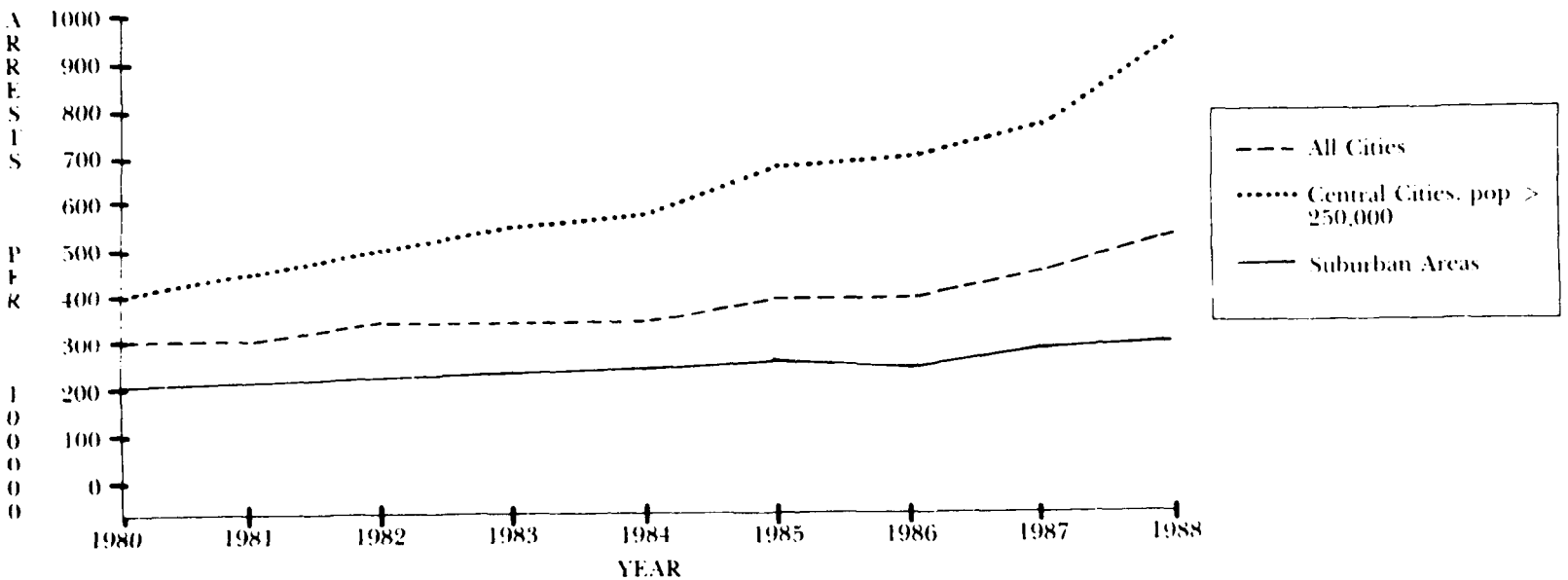
49. Address by William Bennett, American Legislative Exchange Council (July 19, 1989).

50. Federal Bureau of Investigation, Crime in the United States, Uniform Crime Reports 1988, at 171 (1989) [hereinafter Uniform Crime Reports 1988].

51. *See* Kleiman & Smith, *supra* note 38.

52. *See* J. Polich, *supra* note 47, at 15.

Fig 3: Arrest Rates for Drug Abuse Violations
Central Cities and Suburbs: 1980-1988



Source: FBI, Uniform Crime Reports for the United States (published annually).

time of the police or courts.[53] The number of marijuana possession arrests fell from 338,000 in 1980 to 327,000 in 1988; as a percentage of all arrests for drug law violations, this represented a decline from 58% to 28%.[54]

2. Treatment. Most publicly financed treatment for drug abuse is provided directly by county or city health departments or specialized treatment agencies. Programs—detoxification, outpatient, or residential—are operated by public agencies or contractors. In the latter case, the public agency often purchases some, but not all, of the "slots" in a treatment facility. Federal funding for drug treatment comes through the Alcohol, Drug Abuse, and Mental Health (ADM) block grants. State and local governments add funds from general revenues and in most places user fees reimburse a portion of costs. State funds in the aggregate are more than twice the amount of the federal funds.[55] Medicaid, a state program to which the federal government contributes matching funds in different proportions, covers drug abuse treatment in some states, mostly under an optional "clinic services" provision. There are no estimates of how much treatment is currently financed by Medicaid.

3. Prevention. At all levels of government, prevention has always received a far lower proportion of public funds for drug programs than enforcement or treatment. Drug abuse prevention traditionally has been a major concern primarily for the state and local substance abuse agencies handling ADM block grant funds, at least twenty percent of which had to be devoted to prevention activities. Few states spent more than what was required.[56] More recently, the Drug Free Schools and Communities Act created a new system of grants. These grants could be disbursed either through

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53. This statement refers to low-level enforcement. Much of the federal enforcement effort is directed against marijuana importers, and both federal and some local resources are directed against domestic growers and large-scale traffickers. *See generally* M. KLEIMAN, MARIJUANA: COSTS OF ABUSE, COSTS OF CONTROL (1989) (analysis of federal enforcement policies directed against marijuana).

54. UNIFORM CRIME REPORTS 1988, *supra* note 50, at 167.

55. W. BUTYNSKI, D. CANOVA & S. JENSEN, STATE RESOURCES AND SERVICES RELATED TO ALCOHOL AND DRUG ABUSE PROBLEMS, FISCAL YEAR 1988 at 1 (Report for Nat'l Inst. on Alcohol Abuse & Alcoholism and NIDA, 1989) (on file with authors) [hereinafter W. BUTYNSKI].

56. In fiscal year 1987, state drug agencies reported spending 15% of the total of state and federal treatment and prevention funds on prevention programs. *Id.* At the federal level, 15% of all drug-related outlays—international programs, enforcement, treatment, and prevention—in fiscal year 1989 were for prevention. GEN. ACCT. OFF., PUB. NO. GAO/GGD-89-96FS, FEDERAL DRUG-RELATED EFFORTS: BUDGET INFORMATION BY STRATEGY at app. III (June 1989).

the state education agency or through another agency designated by the governor of each state.[57]

School prevention programs vary considerably in content and approach, in the grade levels targeted, and in whether regular classroom teachers, health or physical education specialists, or even nonteachers such as police officers teach the courses.[58] Cities and suburban areas differ greatly in school dropout rates, race and ethnicity, and in the number of young adolescents already involved with drugs. These differences should affect priorities among school and non-school-based prevention programs, between prevention and early intervention, the types of programs adopted, the degree to which they depend on family involvement, and the age groups targeted. Local autonomy and variety have been great, and they are likely to remain so.

B. Drug Policy Needs To Be Coordinated At the Local Level

It is at the state and, especially, the local levels that real coordination is required. At the local level, the action of one agency can have a significant impact on another; ideally, their efforts ought to be coordinated to use their resources most effectively. At a minimum, the agencies ought to be aware of one another's intended actions. Coordination across jurisdictions, among different types of institutions, and between the public and private sectors also pays off when there are significant economies of scale achievable by a common program.

The Strategy proposes several interdepartmental committees to coordinate various aspects of drug control policies, presumably in the belief that coordination by the ONDCP will be more efficient than the system of "lead agencies" that it replaces.[59] The federal government, however, is directly responsible for only the instruments of drug control policy that are least promising for the long term, such as interdiction and source-country drug eradication programs.[60] For the instruments that are receiving new emphasis—

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57. Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, § 4121, 100 Stat. 3207, 3207—127 (repealed 1988).

58. *See* P. REUTER, *supra* note 10, at app. B (description of courses in Washington metropolitan area school districts); Botvin, *Substance Abuse Prevention Research: Recent Developments and Future Directions*, 56 J. SCHOOL HEALTH 369 (1986) (more general discussion).

59. STRATEGY, *supra* note 7, at 16, 46, 84.

60. *See* Reuter, *Can the Borders Be Sealed?*, 92 PUB. INTEREST 51 (1988) (on limitations of interdiction programs); Reuter, *Eternal Hope: America's Quest for Narcotics Control*, 79 PUB. INTEREST 79 (1985) (on limitations of source-country programs); Lee, *Why the U.S.*

street-level enforcement, user sanctions, treatment, and prevention—the federal role is to sponsor research and demonstrations and to provide a fraction of the money.

Little coordination needs to be done at the federal level, since one cabinet department (usually one agency within a department) exercises most of the national government's functions in treatment (Alcohol, Drug Abuse, and Mental Health Administration), local law enforcement (Bureau of Justice Assistance), and prevention (Department of Education). The only potential challenger for the lead agency role in any of these fields is the new Office of Substance Abuse Prevention (OSAP), which since 1986 has taken over prevention responsibilities formerly assigned to NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).[61] The Department of Labor has significant new appropriations for workplace demonstration programs and grants for prevention and treatment, and the Department of Defense is prominent both as a provider and as a purchaser of substance abuse treatment, but neither has yet shown a strong interest at high levels in making drug policy. Coordination of demand reduction policies at the federal level requires little more than the sharing of information about what agencies plan to do in their distinct spheres of action. The role of the ONDCP, most likely in competition with the Office of Management and Budget, would be to recommend priorities among these separate spheres of action for federal expenditures. Once the pot of money has been divided up, there is little reason for the federal agencies to implement their programs in unison.

1. Treatment and punishment. As Figure 3 shows, enforcement of the drug laws has generated an increasing number of arrests. This increase has led to prison overcrowding.[62] Drug law enforcement has also led to a wave of referrals to publicly funded treatment programs, exacerbating the problem of treatment overcrowding. There are no national statistics on sources of referrals to treatment programs, but in the fifteen states that reported data on 1985 admissions to NIDA, 27% of all admissions were coded "non-voluntary"

Cannot Stop South American Cocaine, 32 ORBIS 499 (1988) (on limitations of interdiction and source-country programs).

61. OSAP is still housed within ADAMHA, as are NIDA and NIAAA, so presumably some turf battles and coordination needs could be handled by ADAMHA without recourse to any outside authority. *See* Anti-Drug Abuse Act of 1986, at § 4005, 100 Stat. at 3207—111-14 (codified as amended at 42 U.S.C. § 290aa-6 (Supp. 1989)).

62. *See generally* GEN. ACC'T OFF., PUB. NO. B-234049, PRISON CROWDING: ISSUES FACING THE NATION'S PRISON SYSTEMS (1989).

(and these are mainly referrals from the criminal justice system), ranging from 18% in California to 59% in Texas.[63] In the District of Columbia, referrals from the criminal justice system accounted for just over a third of admissions to public treatment programs in the early 1980s.[64] Between 1985 and 1986, the number of admissions had tripled, and the proportion of criminal justice referrals had risen to over 60%.[65] The biggest period of growth came during and after "Operation Clean Sweep," which began in late 1987,[66] when the District greatly increased law enforcement aimed at street markets.[67] Presumably, in part because of system constraints, prosecutors and judges were willing to accept the argument that many of those picked up in the sweep would be more suitably referred to treatment programs than incarcerated.

No doubt the cocaine epidemic would have put a great strain on big city treatment agencies anyway, but the process might have been less traumatic if corrections and treatment agencies had been able to plan jointly for such an onslaught. In many places, there are some mechanisms for coordination among different parts of the criminal justice system, but coordination among criminal justice and health agencies is much less common and well established.

Ensuring adherence to a treatment regimen after an initial referral requires coordination across institutional boundaries. The experience in New York state is illustrative. From 1967 to 1979, New York had a civil commitment program for arrestees who were or claimed to be drug addicts, with assignments either to special state-operated facilities or, in later years, to private residential facilities.[68] The New York civil commitment program had been intended as the state's major effort in drug abuse treatment, but a number of deficiencies led to its abandonment.[69] One of the most important problems with the programs, according to a recent post-mortem, was a lack of coordination among courts, treatment agencies, and the police.[70] Many of the arrestees referred by the courts to drug abuse treatment, either as a result of the civil proceeding or as a

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63. Nat'l Inst. on Drug Abuse, Demographic Characteristics and Patterns of Drug Use of Clients Admitted to Drug Abuse Treatment Programs in Selected States: Annual Data (1985).

64. P. Reuter, *supra* note 10, at 65.

65. *Id.*

66. *Id.* at 32, 37.

67. *Id.* at 65.

68. *See* Winick, *Some Policy Implications of the New York State Civil Commitment Program*, 18 J. Drug Issues 561 (1988).

69. *Id.* at 563.

70. *Id.* at 564.

condition of probation in a criminal proceeding, simply absconded.[71] Warrants were issued for the arrest of absconders, but executing these warrants was never a priority of the police.[72] Large numbers of those referred to the program were neither punished for their crimes nor treated for their addictions.[73] In the decade since the end of this particular program, the criminal justice system has initiated treatment in a far greater number of cases. If the public treatment system is to reduce demand for illegal drugs and help prevent recidivism, cooperation among treatment and corrections agencies will have to be much more effective than it was during previous drug abuse epidemics.

2. Prevention. Anti-smoking campaigns have provided a model for the current generation of programs, both school-based and community-based, designed to prevent abuse of other substances. Most campaigns that are not exclusively school-based use the mass media either as the primary means for delivering a message or as a means of reinforcing messages delivered face-to-face. Reviewing the experience of anti-smoking campaigns shows that the most successful ones used simultaneous and fairly concentrated delivery of messages through a variety of media.[74] More recently, a community-wide program to prevent use of alcohol and other drugs by young adolescents in the Kansas City area, aimed at both inner city and suburbs, has shown some success in evaluations.[75] The Kansas City effort incorporated many features of successful anti-smoking campaigns, most notably coordination across multiple media and institutions.

The evidence, meager as it is, indicates that boundaries among local jurisdictions and traditional roles of public and private agencies do not correspond well to the requirements of successful prevention campaigns. The relevant geographic area for a campaign like that in Kansas City is probably the media "market area," which often cuts across several counties and independent cities, and in the case of Kansas City, two states. The agencies involved in such efforts can include schools, health care providers (public and private),

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71. *Id.* at 568.

72. *Id.*

73. *Id.* at 566-67.

74. Flay, *Mass Media and Smoking Cessation: A Critical Review*, 77 AM. J. PUB. HEALTH 153, 157 (1987).

75. Pentz, Dwyer, Mackinnon, Flay, Hansen, Wang & Johnson, *A Multi-Community Trial for Primary Prevention of Adolescent Drug Abuse: Effects on Drug Use Prevalence*, 261 J.A.M.A. 3259, 3264 (1989).

social services, recreation departments, churches, local universities, and voluntary and community organizations.

Unlike law enforcement and treatment, most of the agencies involved in prevention of substance abuse have primary missions only peripherally related to substance abuse; prevention is an added task for which they generally do not have full-time trained workers. Typically, the only institutions for which prevention is a primary concern are the small prevention units within the local agencies that handle federal and state ADM funds.

Even if there were funds for large prevention agencies, focusing efforts there might not be the most effective way to change behavior. Substance abuse prevention is intimately involved with forming values and personal habits. People are less likely to look to organs of government for guidance in these matters than to the institutions that Peter Berger and his colleagues have named, in a related context, "mediating structures." These structures include the neighborhood, family, church, and voluntary associations.[76] Outside of schools, government should foster the work of these institutions rather than attempt to deliver services directly. Since useful knowledge is likely to be very specific to particular contexts, such a role is more suited to local officials who know the neighborhoods, churches, and associations involved than to national officials.

Thus in prevention, as in our previous example of law enforcement and treatment, the gains from coordinating policies across agencies and jurisdictions are greater at the local or regional level than at the federal level. The federal role should consist largely of research and dissemination of findings.

III. Trends in Intergovernmental Relations in Drug Abuse Policy

Federal funding for drug abuse treatment and prevention programs and for law enforcement assistance programs has been erratic, growing rapidly during the 1970s, declining for most of the 1980s, and growing rapidly again in the last few years. With the renewed salience of drug problems in the national political agenda, Congress and the executive agencies have made more attempts to set priorities and prescribe drug policy to state and local governments. These attempts, embodied in the 1986 and 1988 Anti-Drug Abuse Acts discussed in this section, and in the recommendations of the National Drug Control Strategy discussed in section IV below,

76. *See generally* P. Berger & R. Neuhaus, To Empower People: The Role of Mediating Structures in Public Policy (American Enterprise Institute for Public Policy Research, 1977).

ignore the local variation in drug problems and the inherently local nature of the instruments of policy.

A. Treatment and Prevention Programs

Centralization of government programs in drug abuse treatment and prevention has increased over the years, beginning in earnest in the 1960s. The early 1980s were an exception to the general trend, as funding was slashed. More recent legislation has returned to the earlier trend.

1. Before 1980. Specialized treatment of drug abuse in the United States began in the 1930s with some pioneering programs for opiate addicts in federal prisons.[77] Few programs for the nonincarcerated existed before the 1960s. In large part because federal policy initiatives in the 1960s and early 1970s made funding available, substance abuse treatment became a distinct and routine function of state and local health departments.

In the 1960s, federal funds weaned states away from reliance on large psychiatric hospitals for dealing with mental health problems of all sorts and fostered the development of Community Mental Health Centers (CMHCs). The Alcoholic and Narcotic Rehabilitation Amendments of 1968 authorized grants to support building and staffing CMHCs in order to "provide incentives for localities to initiate and develop new services for alcoholics and alcohol and drug abusers."[78] Subsequent legislation in 1970 and 1972 set up a system of project and formula grants to states and localities for substance abuse treatment, to be administered by two new institutes within the Department of Health, Education, and Welfare, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism.[79] NIDA and NIAAA also had responsibility for research and demonstration programs. During

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77. In the early years of this century, there had been many private clinics treating opiate and cocaine addiction, but these were closed as federal narcotics prohibition took effect after World War I. *See* DeLong, *Treatment and Rehabilitation*, in DEALING WITH DRUG ABUSE 173-255 (1972) (history of early efforts at drug abuse treatment).

78. Public Health Service Amendments of 1968, Pub. L. No. 90-574, § 301, 82 Stat. 1005, 1006-07 (repealed 1981).

79. The most important authorizations were contained in the Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, § 1, 84 Stat. 1236, 1238-40, and the Drug Abuse Office and Treatment Act of 1972, Pub. L. No. 92-255, 86 Stat. 65, 76-83. In 1974 NIDA and NIAAA were placed under the Alcohol, Drug Abuse, and Mental Health Agency (ADAMHA), along with the National Institute of Mental Health, and this arrangement has remained. Cloud, *Cocaine, Demand, and Addiction: A Study of the Possible Convergence of Rational Theory and National Policy*, 42 VAND. L. REV. 725, 782-83 (1989). Cloud's article contains a good discussion of the legislative history of prevention and treatment programs.

the 1970s, these categorical programs steadily expanded, and the organizational structure of local and state agencies handling the programs tended to reflect the major types of programs: alcohol and other drugs were administratively distinct, each often housed with a mental health or mental hygiene agency, separate from other health and social service agencies.

2. The early Reagan years. The apogee of local autonomy for treatment programs was reached during years of fiscal famine in the 1980s. As in other aspects of social and health policy, the Reagan administration cut overall budgets and reduced the number of federal controls on states by introducing block grants. Title IX of the Omnibus Budget Reconciliation Act of 1981 consolidated all related programs into the Alcohol, Drug, and Mental Health (ADM) block grant.[80] The requirements were few: states had to spend half the funds on mental health programs and half on substance abuse, and of the substance abuse funds at least 35% had to be spent on alcohol programs and at least 35% on other drug programs.[81] Dollars were also few: substance abuse treatment and prevention appropriations fell by exactly one-third from the high point in 1979 ($336 million) to $224 million in 1982, the first full year of the ADM block grant.[82]

When treatment and prevention programs were consolidated into the ADM block grants, and law enforcement assistance grants were almost eliminated, reporting requirements were greatly reduced. In most states, management information systems and evaluation units were allowed to fall into decrepitude.

3. The recent trend. The more recent trend, embodied in several provisions of the Anti-Drug Abuse Act of 1986 and the Anti-Drug Abuse Act of 1988, is an increase in federal funding coupled with a return to categorical grants and activism in the setting of priorities by the federal government. Supplemental appropriations for 1989 under the 1988 Act, for example, stipulated that at least 50% of the additional substance abuse treatment funds were to be spent on programs for intravenous drug abusers, unless states were granted waivers.[83] At least 10% of funds had to be set aside for

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80. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 901, 95 Stat. 357, 535-59.

81. *Id.*, 95 Stat. at 548.

82. *See* Cloud, *supra* note 79, at 783.

83. Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690, § 2030, 102 Stat. 4181, 4200 (codified at 42 U.S.C. § 300x-4(c)(7)(B) (Supp. 1989)).

programs for women, especially pregnant women and their dependent children.[84] As a condition of receiving ADM block grant funds, the same chapter required states to set up revolving funds for the establishment of group homes for recovering alcohol and drug addicts.[85]

Intravenous drug abuse has become a renewed concern of public health officials because it is the most rapidly growing mode of transmission of the AIDS virus. The lack of services for women, and halfway houses for both men and women, often have been identified as crucial gaps in the array of treatment options available in different parts of the country.[86] But these needs vary considerably across states and between urban and suburban areas. Many of the states reporting to the annual surveys of the National Association of State Alcohol and Drug Abuse Directors have identified these services as priorities for new funding within their states, but many have designated other needs, such as treatment programs for drug-involved youth in general, the majority of whom are boys, as more pressing.[87]

In the prevention field, the 1986 and 1988 Acts authorized new grant programs rather than simply expanding the prevention component of the ADM block grants to the states. The "Drug-free Schools and Communities Act," part of the 1986 Act,[88] directed states to spend at least half the new prevention funds on "innovative community-based programs of coordinated services for high-risk youth," defined by various criteria, including pregnancy, poverty, children of substance abusers, school dropouts, etc.[89] The 1988 Act added new categorical programs for runaway youth,[90] youth gangs,[91] and "community youth activities."[92]

For both treatment and prevention programs, increased federal funding in recent years has been accompanied by an increased federal (mainly Congressional) role in specifying how states and localities are to spend the money.

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84. *Id.* at § 2032, 102 Stat. at 4200 (codified at 42 U.S.C. § 300x-4(c)(14) (Supp. 1989)).

85. *Id.* at § 2036, 102 Stat. at 4202 (codified at 42 U.S.C. § 300x (Supp. 1989)).

86. *See* W. BUTYNSKI, *supra* note 55, and earlier reports in the same series from NASADAD for summaries of state agency replies.

87. *Id.*

88. Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, §§ 4101-4144, 100 Stat. 3207, 3207—25-36 (repealed 1988).

89. *Id.* at § 4122(b), 100 Stat. at 3207—127-28 (repealed 1988).

90. Anti-Drug Abuse Act of 1988, at § 3501, 102 Stat. at 4254 (codified at 42 U.S.C. § 11801 (Supp. 1989)).

91. *Id.* at § 3511, 102 Stat. at 4255 (codified at 42 U.S.C. § 11821 (Supp. 1989)).

92. *Id.* at § 3521, 102 Stat. at 4258-59 (codified at 42 U.S.C. § 11841 (Supp. 1989)).

B. Law Enforcement

In the law enforcement area as well, the trend has been toward centralized control and increasing involvement of the federal government. Unlike funding provisions for treatment and prevention, those pertaining to federal involvement in law enforcement did not specify the end uses of funds but attempted to encourage the states to pass funds along to local levels.

The 1986 Act authorized a Drug Law Enforcement Grant program,[93] later reauthorized as the "Drug Control and System Improvement Grant Program" in the 1988 Act,[94] under which the Bureau of Justice Assistance in the U.S. Department of Justice makes formula grants to the states of 80% of appropriated funds and discretionary grants of the remaining 20%.[95] The states then award sub-grants to county and city governments, which make expenditures and then bill the BJA, through their state agencies. In fiscal year 1987, grant awards totalled $178 million; in fiscal year 1988, $56 million; and in fiscal year 1989, $119 million.[96] The 1988 Act merged the grant program set up by the 1986 Act with the Justice Assistance Act grant program to authorize a new state and local law enforcement assistance program. Besides the grant programs, BJA also has programs to provide technical assistance and training to local and state agencies and courts.[97]

City governments have complained that the state governments pass through too small a share of these enforcement grants to them, compared to the shares going to rural and suburban counties. The 1988 Act directed states to "give priority to those jurisdiction with the greatest need" in distributing the grant funds, determining need by using "the most accurate and complete data available."[98]

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93. Anti-Drug Abuse Act of 1986, at § 1552, 100 Stat. at 3207—41-46 (codified in part as amended at 42 U.S.C. § 3796h (Supp. 1988) and repealed in part by Pub. L. No. 100-690, § 6101(a), 102 Stat. 4240 (Supp. 1988)).

94. Anti-Drug Abuse Act of 1988, at § 6091, 102 Stat. at 4329-39 (codified at 42 U.S.C. §§ 3751-3766 (Supp. 1989)).

95. Anti-Drug Abuse Act of 1986, at § 1552, 100 Stat. at 3207—45 (repealed 1988); Anti-Drug Abuse Act of 1988, at § 6091, 102 Stat. at 4336 (codified at 42 U.S.C. § 3761 (Supp. 1989)).

96. *The Drug Enforcement Crisis at the Local Level, Hearing Before the House Select Comm. on Narcotics Abuse and Control* 101st Cong., 1st Sess. 242 (1989) (reprinting BJA records) [hereinafter *House Hearing*].

97. Anti-Drug Abuse Act of 1988, at § 6091, 102 Stat. at 4328 (codified at 42 U.S.C. § 3342 (Supp. 1989)).

98. *Id.*, 102 Stat. at 4334 (codified at 42 U.S.C. §§ 3756(b)(2), 3756(b)(4) (Supp. 1989)).

The U.S. Conference of Mayors published a survey of thirty cities in May 1989.[99] Many reported that they had not yet received any grant funds even though the states had all received their awards for three years. The majority of city governments surveyed reported that they did not know how much they would receive under the fiscal year 1989 grant program, though by that time the states had all known their allocations for at least a month, and the fiscal year was more than half over.[100] Naturally, there are many reasons for such delays, which often include the inability of local governments to comply with program requirements and to make adequate requests on time. But it is easy to understand the attempts, so far unsuccessful, of big-city mayors to modify the block grant programs and influence the design of new categorical programs aimed at drug abuse so that state governments could be bypassed and federal money awarded directly to city governments.[101] The 1988 Act imposed new timetables on the states, requiring speedier pass-through of both ADM and law enforcement grant funds.[102]

The state agencies in turn complain about the time constraints placed on their grant making process by Congress. Congress typically has not dealt with the appropriations bills when the fiscal year starts; until recently, Congress has always appropriated more for drug programs than was requested in the President's budget the previous February, but the amounts have been uncertain until very late in the process. The states are then constrained to make their awards within the time limits, following the various procedural rules. The states want "flexibility," while the cities want more money, quickly.

C. The 1986 and 1988 Acts Ignore Local Variation

The 1986 and 1988 Acts revived the earlier trends of the 1960s and 1970s, bringing stricter federal control over implementation of drug policy. Besides controls of varying degrees of specificity on the uses of grant funds, the 1986 and 1988 Acts imposed planning requirements on the states. The language in the 1986 Act was vague. As a condition of receiving the law enforcement grants,

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99. U.S. CONF. OF MAYORS, A STATUS REPORT ON THE IMPLEMENTATION OF ANTI-DRUG ABUSE BLOCK GRANT PROGRAMS IN CITIES (1989) (reprinted in *House Hearing*, *supra* note 96, at 88-103).

100. *Id.* at 9-11 (reprinted in *House Hearing*, *supra* note 96, at 98-100).

101. *See, e.g.*, *House Hearing*, *supra* note 96, at 5 (testimony of Kathryn Whitmire, Mayor of Houston).

102. Anti-Drug Abuse Act of 1988, at § 6091, 102 Stat. at 4335 (codified at 42 U.S.C. § 3758 (Supp. 1989)).

states were to prepare a "statewide strategy for the enforcement of State and local laws relating to . . . controlled substances."[103] The comparable requirement in the 1988 Act was considerably more specific. It listed seven items that the state plans were to contain, including the establishment of "a statewide strategy for drug and violent crime control programs" and an "analysis of the relationship of the proposed State efforts to the national drug control strategy."[104] This strategy was to be prepared after consultation with local officials.[105] Yet in the survey of city officials by the U.S. Conference of Mayors, most reported that they had not in fact participated in the development of the state plans, and a majority reported that they had not even reviewed the state plans.[106]

In a similar vein, the Drug-Free Schools and Communities Act in 1986 imposed fairly loose planning and coordination requirements; state education agencies were to describe the manner in which they would coordinate their drug prevention efforts with those of the state agency handling the ADM block grant funds,[107] and local education agencies had to "set forth a comprehensive plan" for how they would spend money received under these programs.[108] The 1988 Act set out in much more detail what biennial state reports were to contain, including descriptions of drug and alcohol problems in the schools, descriptions of existing programs and demographic characteristics of the populations served, and information on how the State targeted populations.[109] In both cases (and in the treatment plans that the Strategy has proposed as a requirement for the states), requirements for increasingly detailed planning represent a step back from the more relaxed supervision of the block grant years. Much of the new federal funding for drug abuse has come in the form of categorical grants and set-asides, under which the priorities set by states and local governments are circumscribed; even with less restricted block grant funds, states must justify receiving money with plans and strategies.

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103. Anti-Drug Abuse Act of 1986, at § 1552, 100 Stat. at 3207—42 (repealed 1988).

104. Anti-Drug Abuse Act of 1988, at § 6901, 102 Stat. at 4331-33 (codified at 42 U.S.C. § 3753 (Supp. 1989)).

105. *Id.*

106. U.S. Conf. of Mayors, *supra* note 99, at 9-10 (reprinted in *House Hearing*, *supra* note 96, at 98-99).

107. Anti-Drug Abuse Act of 1986, at § 4123(b)(6), 100 Stat. at 3207—128 (repealed 1988).

108. *Id.* at § 4126(a)(2)(A), 100 Stat. at 3207—130 (repealed 1988).

109. Anti-Drug Abuse Act of 1988, at § 3307, 102 Stat. at 4249-50 (codified at 20 U.S.C. § 3197(a) (Supp. 1989)).

National drug control programs have thus followed a boom-and-bust cycle, with wide swings in funding and program priorities. Many of our current institutions and programs began during the Nixon administration, when heroin, which was concentrated in the big cities of the Northeast and Midwest, caused the greatest concern. The criminal propensities of heroin addicts needing to support their habits figured prominently both in the research agenda and in the policy dialogue.[110] In the early 1980s, drug abuse was less salient as a topic for both the Administration and Congress. Federal funds for treatment and local drug law enforcement dwindled, though the cities were still saddled with large numbers of aging heroin addicts, dependent on public methadone programs since the 1970s.

When drug policy returned to the national political agenda in the mid-1980s, political discussion employed military metaphors, and policy goals short of complete victory were not seriously debated. A characteristically utopian title was given to "The White House Conference for a Drug-Free America";[111] nowhere did the conference report acknowledge that there has never been a drug-free America.

This all-or-nothing thinking is alien to the usual practice of the local police and health departments that actually implement drug policy. One never hears of conferences entitled "A Homicide-Free America" or "A Larceny-Free America" or "A Heart-Disease-Free America." In the history of public health, only one disease, smallpox, has been eradicated worldwide. While several infectious diseases have been nearly eradicated in the United States, no chronic disease, of which addiction is one, has ever been eliminated. Announcing complete eradication of selected drugs as the goal of public policy will hasten disillusion and encourage abandonment of expensive measures to keep drug problems under control.

The "Czar's office" created by the 1988 Act[112] was given a title more in keeping with the everlasting nature of police and public health work. It is an office of "Drug Control Policy." The Strategy formulated by this office added some realism to the discourse at the

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110. The Nixon administration did not rely solely on international and domestic law enforcement to fight heroin. Nixon "appointed a group of liberal, nominally Democratic drug-abuse specialists . . . to lead a relatively humane treatment effort." A. Trebach, The Heroin Solution 233 (1982).

111. White House Conference for a Drug-Free America, Final Report (1988).

112. Anti-Drug Abuse Act of 1988, at § 1002(a), 102 Stat. at 4181 (codified at 21 U.S.C. § 1501 (Supp. 1989)).

national level, and proposed realistic, even modest, goals for reduction in the use of specific drugs; but, it did not counter the centralizing tendencies of recent legislation.

IV. State and Local Drug Policy in the National Drug Control Strategy

The provisions of the 1988 Act establishing the Office of National Drug Control Policy required that its Director produce a National Drug Control Strategy within six months of his confirmation by the Senate and every February 1 thereafter. Among other requirements, the Strategy is to "review State and local drug control activities to ensure that the United States pursues well-coordinated and effective drug control at all levels of government."[113] The Strategy released in September 1989 is far superior to its predecessors produced by the special commissions and the interagency boards that the ONDCP replaced.[114] It summarizes information about the nature and extent of drug problems, proposes priorities, suggests changes, and to some extent discusses implementation of those changes. In short, it deserves the term "Strategy." While the first Strategy does not review current state and local activities in any detail, it argues for sets of recommendations, some addressed to State and local government, and includes an appendix with proposed legislation. The Strategy, at least in its first edition, has continued the path Congress marked with the 1986 and 1988 Acts toward making drug control policy "national." But "national" policy that ignores local variation is an ineffective solution to drug problems.

Rather than return to the "laissez-faire" era of the block grants, the Strategy seems to envisage continuation of the trend toward federal government prescription of priorities in local drug law enforcement and substance abuse treatment. For example, it calls for more specificity in the State treatment plans. As a condition of receiving block grant funds for treatment, each state will be required, according to the Strategy, to submit a plan "which describes how funds will be allocated among treatment facilities, and how local needs have been inventoried and account for in those allocations."[115] The States are to "describe actions they will take to make individual

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113. *Id.* at § 1005(a)(2)(D), 102 Stat. at 4185 (codified at 21 U.S.C. § 1504 (Supp. 1989)).

114. *See, e.g.*, DRUG ABUSE POL'Y OFF., 1984 NATIONAL STRATEGY FOR PREVENTION OF DRUG ABUSE AND DRUG TRAFFICKING.

115. STRATEGY, *supra* note 7, at 39.

treatment facilities more accountable for their effectiveness; to better match drug users with appropriate treatment methods or facilities; to overcome obstacles to site expansion; and to improve coordination with social, health, and employment service agencies."[116] Similarly, the individual state National Guards are required to obtain Department of Defense approval of their drug enforcement plans before receiving federal funds to support those activities.

The enforceability of such conditions is questionable. Federal agencies will find it difficult to formulate objective criteria for determining whether a state plan has dealt seriously with the specified issues or whether local officials have been consulted properly. Lacking objective criteria, federal agencies would find it difficult to justify holding up a state's grants until it had produced a satisfactory plan. Planning requirements may be a device for getting the measures preferred by the ONDCP onto state agendas, rather than a credible threat to cut off grant funds.

1. Expansion of Prison System and Local Drug Law Enforcement

The most expensive proposal in the Strategy and the centerpiece of its enforcement provisions is the expansion of prison capacity. But federal drug policy must rely on the willingness and ability of state governments to fund and implement it.

The Strategy called for increased federal grants to states and localities for street-level law enforcement, from $150 million in fiscal year 1989 to $350 million in fiscal year 1990.[117] Such enforcement generates large numbers of arrests per dollar spent or per police/hour. Jails and prisons are currently overcrowded, with the majority of states operating their prison systems under various kinds of court orders to reduce the crowding.[118] The Strategy calls for an expansion of the federal prison system, but it is silent on the issue of funding for the expansion of the state prison systems. In Senate Judiciary Committee hearings shortly after publication of the Strategy, Senator Joseph Biden pressed Director William Bennett on this point by asking, "How much money does your drug strategy expect

116 *Id.* at 40-41.

117 Even at the increased level, these federal funds for drug law enforcement would amount to less than 1% of the amounts that state and local governments spend on law enforcement, according to the U.S. Conference of Mayors. See CRIMINAL JUSTICE NEWSLETTER, Sept. 15, 1989, at 2 (testimony of Joseph P. Riley).

118 As of April 1989, 35 states and the District of Columbia faced court orders or consent decrees dealing with prison crowding at one or more facilities. GEN. ACC'T OFF., *supra* note 62, at 29.

the states to spend on prisons in order for the drug strategy goals to be met?" Bennett's reply was "certainly several billion dollars." Biden responded by suggesting a figure closer to $10 billion.[119] Because either estimate far exceeds the amounts the federal government grants in law enforcement funds, which in any case cannot be used directly for prison construction, the Strategy's most prominent and expensive provisions can only be put into effect if the states choose to put them into effect. Without a large, expensive, and most likely unpopular expansion of state prisons, the number of arrests and sentences could be increased only if the average length of prison terms were to decrease sufficiently to offset the increase.

The Strategy does propose that states and localities explore "alternative sentencing" options, including "shock camps" for youth, and calls for federal funding to help implement these programs. The Strategy seems to rule out incarceration for first time offenders, stating that "limited prison space should be reserved for the most serious offenders."[120] User sanctions proposed in an Appendix do not include incarceration.[121] But at the same time the Strategy calls on the States and localities for minimum mandatory sentences for serious crimes[122] and "[v]igorous prosecution of and increased fines for all misdemeanor . . . drug offenses."[123]

The Strategy proposes that the federal government attach a condition to the "System Improvement" program grants requiring states to adopt programs for urine testing of arrestees, prisoners, parolees, and those on bail.[124] No legislation imposing this condition has been passed yet, and the Strategy is unclear about how such programs would be implemented. Moreover, implementing such programs would almost certainly demand huge increases in the need for probation services, treatment, or prison capacity.[125] The Strategy presents no cost estimates, but urine testing for all persons in contact with the criminal justice system would require a major reallocation or infusion of funds. The Drug Use Forecasting (DUF)

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119. The exchange between Biden and Bennett is quoted in CRIMINAL JUSTICE NEWSLETTER, *supra* note 117, at 2.

120. STRATEGY, *supra* note 7, at 125.

121. *Id.* at 126.

122. *Id.* at 125.

123. *Id.* at 16.

124. *Id.* at 100.

125. If those under correctional supervision—probation, parole, pretrial release—are subject to monitoring without either treatment or the threat of imprisonment for continued drug use, the programs are unlikely to reduce drug use or crime in the monitored population. If treatment is not available, and agencies return those who test positive, then more will be sent back to correctional facilities more rapidly.

system discussed above is primarily designed to monitor a community's drug problems on the basis of a sample of arrestees.[126] Some jurisdictions have used large-scale testing to predict, on an individual basis, the likelihood of recidivism or abscondment, but implementation of drug testing throughout criminal justice systems would represent a massive new undertaking.[127]

The Strategy also recommends that the states and localities adopt provisions adopted for federal jurisdictions in the 1988 Act and modifications of the Uniform Controlled Substances Act.[128] These include measures for asset forfeiture, special penalties for drug violations near schools, and various user accountability laws, such as suspension of drivers licenses for one to five years and suspension of eligibility for state benefits for one to five years. An earlier draft of the Strategy recommended that states be required to adopt laws providing for suspension of drivers' licenses for drug violations as a condition of receiving federal highway trust funds. This recommendation was dropped, apparently at the insistence of Transportation Secretary Samuel Skinner.[129] The published version of the Strategy makes no recommendations for using any federal monies other than the ADM grants and drug law enforcement grants as devices to force states to adopt drug policy measures preferred by the federal government.

B. Designation of High-Intensity Drug Trafficking Areas

The 1988 Act and the Strategy mark a departure from prior federal drug policy in proposing that some (unspecified) geographic areas be designated as needier of federal resources than others. The 1988 Act authorized ONDCP, in consultation with the Attorney General, other cabinet members, and state governors, to designate "any specified area of the United States" a "high-intensity drug trafficking area" (HIDTA). The Strategy proposes general criteria for selecting an area, including both the local severity of drug problems and the extent to which the drug problems spill over into other

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126. *See supra* text accompanying notes 15-17.

127. *See, e.g.*, Carver, *Drugs and Crime: Controlling Use and Reducing Risk through Testing*, National Institute of Justice Reports, Sept./Oct. 1986 (assessing effectiveness of a D.C. drug testing program in reducing drug abuse in criminal justice system).

128. Strategy, *supra* note 7, at 125.

129. Barnes, *General Bennett*, The New Republic, Sept. 18-25, 1989, at 14; Anti-Drug Abuse Act of 1988, at § 1005(c), 102 Stat. at 4186-87 (codified at 21 U.S.C. § 1504(c) (Supp. 1989)).

places.[130] Selected HIDTAs are to receive intensive federal assistance.[131] In the criminal justice system, this aid could include federal/state/local task forces, assistance with intelligence analysis, resources for drug testing of arrestees, parolees, and persons on probation, and other types of support provided by the Bureau of Justice Assistance. The Strategy also provides for assistance to increase security at public housing facilities and allow waiver of HUD regulations to facilitate quick evictions of public housing tenants involved in drug selling. Still other provisions provide support for community and worksite prevention programs.

None of these provisions differs much from what the Strategy recommends for the entire country. Presumably, the advantage for an area designated as an HIDTA would be receiving more help sooner. The Strategy omits the question of how much of the resources directed to HIDTAs under these headings would consist of money for new programs and new permanent staff and how much would be temporary reassignment of federal personnel. The Strategy speaks only of HIDTA "activities that may be supported by such reallocation of federal resources."[132]

Even before the Strategy had been published, the ONDCP tested the concept of concentrating federal resources on severely affected metropolitan areas by announcing a special plan for the Washington, D.C. area.[133] The most expensive part of the plan was a provision for construction of two new prisons to house drug offenders from the Washington area. One was to be in the District of Columbia, which had been planning a new prison for four years but has been forced to delay construction in part by a lawsuit initiated by residents of the area where construction was planned.[134] The other prison was to be a 700-bed federal facility built somewhere in the suburbs. No site was named formally for the latter, but the ONDCP and the Bureau of Prisons originally proposed Fort Meade in Anne Arundel County, Maryland. Responding to the strong opposition of

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130. STRATEGY, *supra* note 7, at 129-30. The first annual follow-up to the Strategy was issued after this Article had been written. In that subsequent report, the ONDCP Director designated five areas as HIDTAs: New York City, Los Angeles, Miami, Houston, and counties along the Mexican border. OFF. OF NAT'L DRUG CONTROL STRATEGY, THE WHITE HOUSE, NATIONAL DRUG CONTROL STRATEGY at app. A (1990).

131. STRATEGY, *supra* note 7, at 129-30.

132. *Id.* at 129.

133. *Bennett Unveils Plan to Combat Washington Drug Crisis*, Wash. Post, Apr. 11, 1989, at A1, col. 5.

134. Horwitz & Spolar, *Bennett Faces Inherent Hurdles in Plan to Rid D.C. of Drugs*, Wash. Post, Apr. 11, 1989, at A12, col. 1.

Anne Arundel residents and legislators, Maryland Governor William Donald Schaefer announced that he had received an assurance from ONDCP Director Bennett that the prison would not be built at Fort Meade.[135] The Fort Meade site was abandoned without an alternative.

The Bureau of Prisons then announced plans to accelerate the long planned construction of a new federal prison in Cumberland, in western Maryland. Since the original Washington area plan seemed to call for a high-security prison while the plans for Cumberland were for a medium-security one, the confusing nature of this announcement annoyed Allegheny County officials and western Maryland's Congressional representative. The Bureau apparently has backed down from its plans for a new federal prison for Washington area drug offenders. According to ONDCP officials, the Cumberland facility, as originally planned, would eliminate the immediate need for the new prison in the Washington area, but would "not be specifically dedicated for prisoners in the Washington area."[136]

Other parts of the Washington plan called for NIDA to operate three new model outpatient drug treatment programs and for the Drug Enforcement Administration to assist in a new task force with local police agencies. At the time of the announcement, DEA officials reported that they did not know where they were going to get the money for the task force.[137] NIDA did not know where it would locate the three new treatment programs, and District officials had been trying for two years to get new programs in several wards of the city but residents had successfully blocked the plans.[138]

It would be unfair to judge the ability of the ONDCP to concentrate federal resources on one metropolitan area and impose a regional anti-drug policy solely on the evidence of this experience in Washington. At the time of the Washington proposal, the ONDCP was new and not fully staffed. Washington is a difficult area in which to coordinate regional initiatives, since two separate state governments and that of the District are involved. Finally, relations between the federal government and the District government are

135. Isikoff, *Missteps on the Road to District Drug Plan*, Wash. Post, Apr. 23, 1989, at A22, col. 1.
136. *D.C. Area Not Getting New Prison*, Wash. Post, Apr. 16, 1989, at A1, col. 5.
137. Isikoff, *supra* note 135.
138. *Id.*

exceptionally poor.[139] But the Washington experience does suggest a number of lessons. First, the expansion of the federal and state prison systems on which the Strategy is predicated cannot be expected to take place quickly, if at all. An attempt by federal officials to hurry plans and force action can upset years of careful compromise with elected representatives, state and local officials, as it did in Allegheny County, or even incite a united and invincible opposition front, as it did in Anne Arundel County. Second, the federal agencies best suited to participate in negotiations with Congress, subnational levels of government, and community groups may be the large, well established spending agencies with regional staff. The ONDCP is the only federal agency with a system-wide perspective on the drug problem, but it is not big enough to devote staff to the detailed preparations and interminable negotiations required to get sites approved for facilities like drug treatment clinics and prisons over the objections of neighbors. Siting unpopular facilities is a delicate subject, which elected officials prefer to avoid, and in which multiple layers of government must participate. Unless the commitment to intensified law enforcement and increased treatment is abandoned, drug policy in the next decade will largely involve just such tasks of siting new (or expanding current) facilities.

The Strategy thus does not recognize sufficiently the diversity of drug problems or the appropriateness and feasibility of different measures in different places. The Strategy's one acknowledgement of local variation is the provision for designation of HIDTAs, and even that seems to picture what those areas need as "the same, only more so."

V. Conclusions

State and local decisionmakers should be given latitude to make and implement drug control policy. Even in the midst of a national cocaine epidemic, patterns of drug abuse, and the social consequences of drug use and drug trafficking, differ significantly across regions, between urban and suburban areas, and among cities. The instruments of drug policy that now appear most promising—prevention and early intervention, treatment, and street-level law enforcement—are wielded by local institutions: the schools, health

139. Mayor Marion Barry of Washington was not invited to the press conference at which the plan was announced. *Barry Aides Say Help is Too Much, Not Enough*, Wash. Post, Apr. 11, 1989, at A1, col. 2.

care providers under contract, and local police. The needs for coordination are at the local, not national, level.

Perhaps most importantly, there is no model drug policy on the shelf. No one at any level of government can discern with confidence the effectiveness of our current mix of laws and programs, and no one can predict with confidence the effects of any proposed changes. The Strategy is commendably honest on this score; it relies often on induction and analogies drawn from other spheres of public health and safety, and admits in several places that the empirical basis for pronouncements is thin.[140] Conditions would seem ideal for what Robert LaFollette and the Progressive reformers called "the laboratory of the states." Since no community has solved its drug problem, each could adopt different strategies and see what works after the fact; the wider the variety, the more information to be gained from the experiment.[141] The recent actions of Congress, including the 1986 and 1988 Acts, and the recent pronouncements of the executive branch, including the Strategy, show a tendency toward renewed centralization. The Director of the ONDCP did state in a recent speech to state officials that "[n]early all of the institutions that must deal with the everyday reality of the crack epidemic—police, judges, schools, courts—are creatures of state government. . . . That is why any plan to solve the crack problem must involve the active cooperation of the states."[142] But active cooperation in implementing measures chosen at the federal level is what he appears to have meant, since in the body of the same speech he called "on the states to act on five specific concerns."[143]

Decentralization of policymaking was promoted only during the first half of the 1980s, when budgets were declining and drug abuse was not a salient political topic. But the explanation by the Director of NIDA for the decision to remove management of programs from the federal agencies with the creation of block grants in 1981 still

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140. In particular, recommendations concerning treatment strategy acknowledge the inadequacy of data about which methods are effective. Though firm proposals are nonetheless made, the Strategy admits the need for improvements in several areas of data collection. STRATEGY, *supra* note 7, at 39, 43, 81-82.

141. There are limits on the range of options states and cities could try. Kurt Schmoke, Baltimore's mayor, is a prominent advocate of legalization of some drugs; if Baltimore legalized cocaine trafficking de facto, through non-enforcement, it would be very difficult for its neighbors to maintain an effective ban. But the limits are very wide, even if they do not encompass extremes. Baltimore could de-emphasize or target enforcement and expand treatment facilities without badly subverting the drug policies of its neighbors.

142. Address by William Bennett, *supra* note 49.

143. *Id.*

obtains: "The restructuring of assistance was based on a conviction that States are better able to plan, allocate funds for, and monitor health programs within their boundaries than is the Federal Government."[144] Unfortunately, that conviction has been overturned. During the 1990s, the trend towards centralization of drug policy making should be reversed. The federal government should resist the temptation to impose from above a solution to the nation's drug problems. Nothing about the previous experience of anti-drug efforts (at any level of government, it must be admitted) should give us confidence that the solution is known. The diversity of drug abuse problems and their consequences makes it unlikely that there is a single solution applicable in all cities. Though it would not fit well with the currently popular "war" metaphor, the next White House conference on drug policy might adopt for its title the slogan briefly used by Mao Zedong: "Let a Hundred Flowers Bloom. Let a Hundred Schools of Thought Contend."

144. Schuster, *The National Institute on Drug Abuse*, 84 BRIT. J. OF ADDICTION 19, 20 (1989).